SECTION 4.000 SPECIAL PAYMENT RATE ADJUSTMENTS AND RECALCULATIONS

4.100 RETROACTIVE RATE ADJUSTMENTS

4.110 Retroactivity

The Department has the authority to retroactively adjust the daily rate in such circumstances as audit adjustments, errors in reporting, errors in calculations, implementation of administrative formula provisions, and implementation of rules enacted under s. 49.45(10), Wis. Stats.

4.115 Administrative Reviews and Appeals

Sections 4.110 through 4.150 do not apply to administrative reviews under Section 1.800 or to appeals under Section 1.400 or Section 1.700. The time limits within which administrative reviews or appeals must be filed are determined under the relevant section, rule, and guidelines.

4.120 Material Adjustments

Only audit adjustments and/or corrections of errors which have a combined net material impact on rates and payments for services will be incorporated into the rates. "Material" is defined as the combined net increase or decrease being equal to or greater than an average change of $.050 per patient day. The average change shall be calculated on a weighted average of the change in each level of care payment rate using the patient days from the calculation of the average base rate (See Section 3.710). The materiality test will be applied separately each time payment rates are recalculated for the correction of errors or audit adjustments with the newly-adjusted rates being compared to the rates being corrected or adjusted.

4.130 Within 150 Days

A provider must deliver written notice of errors to the Department within 150 days of the date of the first rate approval letter in order for any corrected rates to take effect on the original effective date of the rates in error. A postmark date shall be considered delivery date. The provider will be limited to only one such retroactive adjustment per rate effective period in order to correct errors in reported data. Departmental corrections to the rate calculation mechanics of the Department shall not be limited to one such retroactive adjustment. Notice or approval of a corrected rate does not initiate a new 150-day period.

If errors are found by the Department, increased corrected rates will be effective on the first of the month following the month in which the error was found and decreased corrected rates will be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and allowed to be retroactively effective in conjunction with the corrections resulting from the notice from the provider.

4.140 After 150 Days

If the provider delivers written notice of errors to the Department more than 150 days after the date of the first rate approval letter, corrected increased rates will be effective the first of the month following the month in which the notice was delivered to the Department. Corrected decreased rates from such notice shall be effective on the original effective date of the corrected rates. A postmark date shall be considered delivery date.

If errors are found by the Department, corrected increased rates will be effective the first of the month following the month in which found by the Department. Corrected decreased rates shall be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and be effective in conjunction with the corrections resulting from the notice from the provider.

4.150 Audits

Any findings of the Department in the course of an audit shall be considered findings coincident to any written notice of errors delivered by the provider to the Department in the course of the audit. Such corrections submitted by the provider shall be taken into consideration in conjunction with and incorporated with any findings of the Department when determining audit adjusted payment rates. An audit shall be considered completed on the date of the approval letter of the audit adjusted payment rates. This completion date initiates the 150-day period described in Section 4.130.

4.200 CHANGE OF OWNERSHIP

4.210 No Rate Change for New Owner

There shall be no payment rate recalculation due to the change of ownership of a facility or operation which occurs during the payment rate year described in Section 1.130. The new provider will be paid the rate which the former owner was paid or would have been paid if no change of ownership had occurred, unless other provisions of this Section 4.000 allow adjustments to the payment rate. If the change of ownership occurred prior to the payment rate year, July 1 payment rates shall be determined based on a cost reporting period allowed under Section 1.302.

4.220 Prior Owner's Cost Report Required

The cost report for the period during which the facility was operated by the previous owner is still required and must be submitted to the Department unless the Department determines the cost report is not needed. THE NEW OWNER SHOULD ASSURE THE PRIOR OWNER'S COST REPORT IS SUBMITTED. The cost report is presumed to be needed in order for the Department to obtain sufficient data for a full twelve month base cost reporting period allowed under Section 1.302. In those rare instances where it may be impossible to obtain the prior owner's cost report, the Department may determine it is not needed if the cost reporting period for the new owner allowable under Section 1.302 covers a period of at least six months. If the prior owner's cost report is needed, but not submitted, the new provider's rates for the payment rate year specified in Section 1.130 will default to the facility's June 30th rate of the prior payment rate year, exclusive of any amounts for ancillary add-ons and Nursing Home Appeals Board awards and special allowances for local government operated facilities. The Department may reduce those rates by no more than 25.0% if deemed appropriate.

4.230 Property Tax

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership.

4.300 PAYMENT RATES FOR NEW FACILITIES

4.301 General

Payment rates for a new facility will be established under the rate calculation provisions of Section 3.000. The rate computation will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates. The Department will establish interim rates until rates can be finalized under this section. New facilities are defined in Section 1.305. The Department may deny approval of any rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the new facility. Allowable costs will be deflated and inflated as appropriate with the indices in Section 5.300 and the provisions of the current Methods applied. The property allowance shall be calculated under the provisions of Section 3.500.

The provisions of Sections 4.300 through 4.360 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.310 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the facility was licensed. A facility certified for the Medicaid Program after this twelve-month period shall be considered to have completed its start-up period.

4.320 Payment Rates During the Start-Up Period

Payment rates for the start-up period shall be retrospectively established based on one or more cost reports for the start-up period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the date of certification for Medicaid, and (2) end on, or within the five calendar months after, the end date of the start-up period. The payment rates shall not be effective earlier than the certification date and shall lapse not later than at the end of the start-up period.

The minimum patient days for the administrative expense component (Section 3.230), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of patient days at 50.0% occupancy of average licensed beds or adjusted patient days during the cost reporting period.

4.330 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a new facility shall be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting periods used under Section 4.320. The minimum patient day occupancy standards under Section 3.000 shall apply.

4.332 Modified Cost Report Period
The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.333 Base Rates
The base rates for a newly-licensed facility are described in Section 3.722, item 4.

4.335 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing a new facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, then the July payment rates shall be established under the retrospective provisions for the start-up period. If the cost reporting fiscal year specified in Section 1.302 begins before or during the start-up period, then the Department may designate a more current base cost reporting period for July rates.

4.350 Inflationary Adjustment of Expenses
Cost data from any cost reporting period described above will be inflated or deflated to the common period described in Section 1.303.

4.360 Property Tax Allowance
The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for a new facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.400 PAYMENT RATES FOR SIGNIFICANT INCREASES IN LICENSED BEDS

4.401 General
The Department may require or a provider may request the payment rate to be reestablished under the provisions of Section 3.000 when a provider significantly increases its unrestricted use licensed beds. The rate computations will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates.

The Department may establish interim rates until rates can be finalized under this section. A significant increase in licensed beds is defined in Section 1.304. The Department may deny approving any adjusted rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the expanded facility. The property allowance shall be recalculated under the provisions of Section 3.500.

The provisions of Sections 4.400 through 4.460 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.410 Start-Up Period
The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the new beds were licensed.

4.420 Payment Rates During the Start-Up Period
Application of this section is optional. Payment rates for the start-up period may be retrospectively established based on one or more cost reports for the start-up period for any or all applicable payment allowances. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the start-up period, and (2) end on, or within the five calendar months after, the end date of the start-up period. The adjusted payment rates shall be effective as of the date of amended licensure.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of adjusted patient days or patient days at the minimum occupancy rate described here. The minimum occupancy rate shall be based on: (1) 50.0% of the increase in licensed beds, and (2) the average daily occupancy in the six calendar months immediately preceding the increase in licensed beds during which no substantial number of licensed beds were out-of-use due to any renovation or construction. The occupancy rate in (2) above must be 90.5% or greater.

4.430 Payment Rates After the Start-Up Period
After completion of the start-up period, rates for a significantly expanded provider may be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting period used in Section 4.420. The minimum patient day occupancy standards under Section 3.000 shall apply. Section 4.430 may be applied to the significantly expanded provider which does not receive a retrospective adjustment under Section 4.420.

4.432 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.433 Base Rates
The base rates for a significantly expanded facility are described in Section 3.722, item 3.

4.435 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing an expanded facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, July payment rates may be established under the retrospective provisions for the start-up period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the start-up period, the Department may designate a more current base cost reporting period for July 1 rates.

4.460 Property Tax Allowance
The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for an expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.500 PAYMENT RATES FOR SIGNIFICANT DECREASES IN LICENSED BEDS

4.501 General
A provider may plan to significantly decrease its number of unrestricted use licensed beds. The Department may require or the provider may request payment rates to be reestablished. If the provider makes the request, the provider must notify the Department in writing prior to the effective date of the reestablished rates and must relinquish the future use of a significant number of licensed beds. Any future use of the relinquished beds must be approved, if required, under Chapter 150, Wis. Stats. The Department may deny rate adjustments under this section if it determines the provider's decrease is not desirable or appropriate.

If the reduction involves an extended and major phase-down, the provider may elect to have rates established under the provisions of Section 4.560 below. If Section 4.560 is not applied, the rate computation will consist of two phases: (1) retrospective rates for the phase-down period, and (2) post phase-down adjusted rates. A significant decrease is defined in Section 1.304. The property allowance shall be recalculated, subject to the targets, maximums and ratios described in Section 3.500.

The provisions of Sections 4.500 through 4.560 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.501(a) Sale of Beds
A rate adjustment will be made under this section only when a provider has surrendered the right to license these beds for reallocation through the Resource Allocation Program (RAP). Thus, where a provider has sold or transferred his right to license beds, without going through the RAP process, the phase-down and facility closing provisions will not be used to adjust Medicaid rates for the facility that is reducing licensed bed capacity.

The costs of acquiring the right to license beds from another provider are non-reimbursable costs.

4.510 Phase-Down Period
The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period which may be modified as needed during the phase-down.

4.520 Payment Rates During the Phase-Down Period
Application of this section is optional. Payment rates for the phase-down period shall be retrospectively established under Section 3.000 based on one or more cost reports. No retrospective adjustment shall be available if the phase-down period is less than six months. The cost reporting period(s) shall: (1) begin on, or within the five calendar months before or the five calendar months after, the starting date of the phase-down period, and (2) end on, or within the five calendar months after, the effective date of the amended license at the objective capacity. The retrospective payment rates shall not be effective earlier than the beginning date of the cost reporting period and shall lapse at the end of the reporting period.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500), shall be the greater of patient days at 96.0% occupancy of the objective licensed bed capacity or adjusted patient days during the cost reporting period.

4.530 Payment Rates After the Phase-Down Period
After a provider's license is amended to the objective licensed bed capacity, payment rates may be reestablished based on at least a six-month cost report acceptable to the Department which will begin after the end of the phase-down period or after the end of the cost reporting period used under Section 4.520. Section 4.530 may be applied to the significantly decreased provider which does not receive a retrospective adjustment under Section 4.520. The minimum occupancy standards in Section 3.000 shall apply for determining payment rates after the phase-down period.

4.532 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.535 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing the decreased facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the phase-down period includes the July 1 date, then the July payment rates may be established under the retrospective provisions for the phase-down period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the phase-down period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.550 Inflationary Adjustment of Expenses
Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.560 Major Phase-Down
A major phase-down is: (1) a significant reduction in unrestricted use licensed beds, and (2) a reduction of resident population by 15.0% or more. The determination of the extent of the reduction of resident population shall be based on the average daily resident census, including each bed hold day as one full day, during the cost reporting period which would have been used for establishing payment rates in the first month of the phase-down period if no phase-down rate adjustment had been pursued. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.580 Facility Closings
A provider may choose to phase out its nursing home operation. In such cases, the provider may request, or the Department may require, an adjustment to payment rates for the period of the phase-out. The Department may deny rate adjustments under this section if it determines the provider's phase-out is not desirable or appropriate. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.600 CHANGE IN FACILITY CERTIFICATION OR LICENSURE

4.601 General
If a provider changes its certification, including certification in whole or in part as an ICF-MR or licensure level, the Department may require, or the facility may request, payment rates to be reestablished under Section 3.000. Only the direct care allowance under Section 3.100 and the final rates under Section 3.700 will be recalculated, based on a cost reporting period for patient days and for direct care wages, purchased services and supply expenses. In lieu of reporting new supply expenses, previously allowed supply expenses may be used in the recalculation if acceptable to the Department. The rate computations will consist of two phases: (1) retrospective rates for the change-over period, and (2) post change-over period adjusted rates. The Department may establish interim rates until rates are finalized. The Department may deny reestablishing payment rates if any required Chapter 150 approval was not received. The Chapter 150 rate maximum, per Section 1.600, shall apply, if applicable, to the facility.

4.602 Exceptions
The provisions of Section 4.600 do not apply to a facility certified as a skilled nursing facility (SNF) solely acquiring certification as a nursing facility (NF). Section 4.600 delineates provisions for rate adjustments for facility converting to ICF-MR certification.

4.605 Rates Not Reestablished
If rates are not reestablished upon a change in certification or licensure level, then the payment rate for any added level of care shall be the rate from the next lower level of care.

4.610 Change-Over Period
The change-over period shall be at least a six-month period but no more than a twelve-month period beginning on the first of the month following the month in which the change was effective.

4.620 Payment Rates During Change-Over Period
Application of this section is optional, and if it is not applied, then Section 4.610 will apply. Payment rates for the change-over period may be retrospectively established based on one or more cost reports for the change-over period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the change-over period, and (2) end on, or within the five calendar months after, the end date of the change-over period. The adjusted payment rates shall be effective as of the effective date of the applicable change.

4.630 Payment Rates After the Change-Over Period
After completion of the change-over period, rates for a changed provider may be reestablished based on at least a six-month cost report for patient days and for direct care wages, purchased services and supply expenses. Such cost reporting period shall begin after the end of the change-over period or after the end of the optional cost reporting period used under Section 4.620.

4.632 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year end, reimbursement period, or other cost reports required in different sections of these Methods to permit more efficient or reliable cost reporting.

4.635 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing a changed facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the change-over period includes the July 1 date, then payment rates for July through the end of the change-over period may be established under the retrospective provisions for change-over period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the change-over period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.650 Inflationary Adjustment of Expenses
Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.690 Special Care Payments/Non Rate Payments

4.691 Ventilator Dependent and Extensive Care Patients
Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department, payment of $375 per day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Payment for related extensive care patients prior authorized for care at the $150 rate before July 1, 1989 will continue to receive this rate, with appropriate continued prior authorization for the payment rate year.

4.692 Facilities for the Treatment of Head Injuries
Facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by

5.160 Durable Medical Equipment and Wheelchairs - Exceptions

5.162 General
Durable medical equipment and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipients without charge to the patient, the patient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate.

Under certain exceptions, durable medical equipment (DME) and wheelchairs may be billed separately by the supplier if prior authorized. The prior authorization request must document the need for the item according to the exception criteria described below.

5.164 Durable Medical Equipment
Exceptions to permit separate payment for DME may be allowed by the Department if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. These items include orthoses, prostheses (including hearing aids), orthopedic or corrective shoes, or pressure relief beds.

5.166 Special Adaptive Positioning or Electric Wheelchairs
The Department may permit separate payment for a special adaptive positioning or electric wheelchair, while a recipient resides in a nursing home, if the wheelchair is prescribed by a physician and the following criteria are met:

1. The wheelchair is personalized in nature or is custom-made for a patient and is used by the resident on an individual basis for hygienic or other reasons, AND

2. The special adaptive positioning wheelchair or electric wheelchair is justified by the diagnosis and prognosis and the occupational or vocational activities of the recipient (i.e., educational, therapeutic involvement).

Exceptions for wheelchairs may be allowed for the recipient who is about to transfer from a nursing home to an alternate and more independent setting.

5.167 References
Information regarding DME and wheelchairs is contained in HFS 107.24, Wis. Adm. Code, and in the DME Provider Handbook. (For more information on prior authorization, see HFS 107.02(3), Wis. Adm. Code.)

5.200 OVER-THE-COUNTER DRUGS

5.210 General
Certain over-the-counter drugs are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

The following is a partial list of items covered by Section 5.200. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

Aspirin	Vaginal products	Hemorrhoidal products
Ibuprofen	Digestive aids	Antibiotic Ointment
Vitamins	Saliva substitutes	Pediculicides
Non-covered cough & cold products	Acetaminophen	Decubitus treatments
Non-covered ophthalmic products	Laxatives	Capaicin Topical Products
Topical steroids	Minerals	Antidiarrheals
Antifungals	Antihistamines	

The above list does not represent the entire list of drugs covered under Section 5.200 and other non-covered over-the-counter drugs may be added to this section. Over-the-counter drugs covered under this section must be on the Division of Health Care Financing's approved OTC list or index.

5.300 COST REPORT INFLATION AND DEFLATION FACTORS

Inflation and deflation factors to adjust expenses from nursing home cost reports to the common period are given below. The common period is the twelve-month period prior to the payment rate year. The factors listed below apply to annual nursing home cost reports ending in the following months.

5.150 All Non-Expendable, Reusable Materials

Abdominal binder
Abdominal support
Adaptive dressing equipment
Adaptive eating utensils
Adaptive hygiene equipment
Air cleaner
Air splints
All non-expendable, reusable materials (bedpans, thermometers, Towels, linen, ace bandages, rubber pants, etc.)
Alternating pressure pumps
Apnea monitor
Aquaped (K pad)

Bath bench
Bath lifts
Bath sling
Bed, electric
Bed, hospital
Bed rails
Blood glucose monitor

Commodes
Crib, hospital-type
Crib with enclosed top
Cushions, all types, wheelchairs

Elbow protectors
Elevated toilet seats
Enuretic alarm
Exercise equipment
Exercycle (exercise bike)

Floor stand, trapeze
Floor stand, weights
Flotation pads
Food pumps
Foot boards (model)
Foot protectors

Geriatric chairs
Gait belts

Hand cones
Hand splints, soft
Hosiery, including support and thrombo-embolytic disease stockings
Hoyer or other hydraulic or non-hydraulic lift
Humidifier
IPPB (Intermittent positive pressure machine)
IV Poles

Lamp, heat and ultraviolet Lap boards/trays, wheelchair

Mat, exercise
Mattress, air, alternating pressure, gel, foam
Mattress pads
Lower extremity splints/positioners (e.g. mulitodus)

Name tags

Oxygen masks, canulas, tubing, nebulizer, flow meter

Patient lifts
Positioning equipment for wheelchairs, chairs and beds
Prone standers
Pulse oximeter

Reachers
Restraints
Roho, Jay or similar flotation cushion

Safety rails – hallways, bathroom areas (tub, toilet, shower)
Sitz baths – portable
Sliding boards
Standing tables
Suction machine (standard)

TENS units
Transfer devices
Traction apparatus
Trapeze
Tub, rail

Vaporizer, room
Volumetric pump

Walkers, canes, crutches (including quad-canes)
Water mattress
Wheelchairs, all manual
Wheelchairs, power (See Sec 5.160)
Whirlpool
Wrist bands and alarm systems

Gloves (latex and vinyl)

Hydrogen peroxide

Lemon or glycerin swabs
Lubricating jellies (Vaseline, KY jelly, etc.)

Oral hygiene products (dental floss, toothpaste, toothbrush, Waterpik)

Phosphate enemas
Plastic or adhesive bandages (e.g. Band-aids)

Shampoos (except specialized shampoos as Selsun and similar products)
Soaps (antiseptic and non-antiseptic)
Straws (paper and plastic)
Syringes and needles, Lancets (disposable and reusable)

Tapes, all types
Tincture of benzoin
Tongue depressors
Tracheotomy care sets and suction catheters
Tube feeding sets and components part

NOTE: Although these are the most common of the personal comfort items, this is not intended to be an all-inclusive list. Exceptional supply needs subject to prior authorization are based upon the Department's guidelines pursuant to Section 4.695.

5.400 DIRECT CARE PAYMENT PARAMETERS

5.410 Labor Factors

County	Labor Factor
Adams	0.945
Ashland	0.945
Barron	0.945
Bayfield	0.945
Brown	1.017
Buffalo	0.945
Burnett	0.945
Calumet	1.019
Chippewa	0.952
Clark	0.945
Columbia	0.945
Crawford	0.945
Dane	1.101
Dodge	0.945
Door	0.945
Douglas	1.114
Dunn	0.945
Eau Claire	0.952
Florence	0.945
Fond du Lac	0.945
Forest	0.945
Grant	0.945
Green	0.945
Green Lake	0.945
Iowa	0.945
Iron	0.945
Jackson	0.945
Jefferson	0.945
Juneau	0.945
Kenosha	0.996
Kewaunee	0.945
La Crosse	0.996
Lafayette	0.945
Langlade	0.945
Lincoln	0.945
Manitowoc	0.945
Marathon	1.032
Marinette	0.945
Marquette	0.945
Milwaukee	1.081
Monroe	0.945
Oconto	0.945

County	Labor Factor
Oneida	0.945
Outagamie	1.019
Ozaukee	1.081
Pepin	0.945
Pierce	1.171
Polk	0.945
Portage	0.945
Price	0.945
Racine	0.953
Richland	0.945
Rock	1.050
Rusk	0.945
St. Croix	1.171
Sauk	0.945
Sawyer	0.945
Shawano	0.945
Sheboygan	1.026
Taylor	0.945
Trempealeau	0.945
Vernon	0.945
Vilas	0.945
Walworth	0.945
Washburn	0.945
Washington	1.081
Waukesha	1.081
Waupaca	0.945
Waushara	0.945
Winnebago	1.019
Wood	0.945
Menominee	0.945